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Ms. Linda Cole
Chief
Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Comments of Seasons Hospice and Palliative Services of Maryland, Inc. To Proposed State Health Plan for Facilities and Services: Nursing Home, Home Health Agency and Hospice Services, COMAR 10.24.08

Dear Ms. Cole:

Seasons Hospice and Palliative Services of Maryland, Inc., appreciates the opportunity which the Commission has extended to us to submit informal comments with respect to this proposed State Health Plan section, specifically as it relates to hospice services. Seasons currently provides services in Baltimore City, Baltimore County, Harford, Howard, Anne Arundel, Carroll and Prince George's Counties. Seasons also provides services in Illinois, Wisconsin, Michigan and Arizona. We believe that Seasons' comments may be of particular use to the Commission because of Season's broad experiences in the delivery of hospice services.

We will focus our comments on the need provisions of the State Health Plan as they relate to hospice services, COMAR 10.24.08.15. In particular, Seasons believes that need for Carroll County and Prince George's Counties has not been properly calculated.

1. Carroll County and Prince George's County.

In 2003, the General Assembly passed S.B. 732, later codified as Health-General Art. Sec. 19-906 which had the effect of revoking the license of a hospice provider to provide services in a particular county if that provider had not served a patient in that county during calendar year 2001. In late 2003, Seasons purchased VNA Hospice Services, Inc., a subsidiary of VNA, Inc., and its rights to provide hospice services in Maryland. Although VNA Hospice had provided services in Carroll County and Prince George's County both before and after 2001, VNA Hospice had not provided services during that year. Under the statute, the State Office of

Health Care Quality commenced proceedings to revoke the license of VNA Hospice and its successor Seasons to operate in the two counties. As a result, Seasons provided no services there during 2004.

However, in March 2005, the Circuit Court for Baltimore County ruled that § 19-906, was unconstitutional under Maryland's Constitution and Declaration of Rights, and that Seasons had the right to offer hospice services in the two counties. Since that date, Seasons has been an active provider of services in good standing in both counties.

The calculation of need which appears in the chart entitled Hospice Program Need Projections by Jurisdiction, Region and Statewide, Maryland, 2010 includes in column 4, the number of deaths and live discharges in 2004 in both Carroll and Prince George's Counties. This number of course plays an integral part in the determination of need in these counties.

However, in 2004, Seasons was unable to provide services in either county because of the litigation over the State's efforts to revoke its license to operate in the two counties. After the Court ruled this effort to be unconstitutional, Seasons did begin to provide services in the two counties.

Clearly, the chart in the October 5 Revised document substantially overestimated the net need for hospice services in both counties in that it has failed to take account of Season's presence in the counties.

There is an additional problem with respect to Carroll County. The Plan section distinguishes between rural and urban counties by establishing a lower volume threshold for rural counties. Thus, the volume threshold in an urban county is 164 patient deaths and live discharges whereas the threshold is 609 for an urban county.

The chart entitled "Hospice Program need Projections by Jurisdiction, Region and Statewide, Maryland: 2010 (Revised October 5, 2006) applies the urban volume threshold of 609 to the large suburban D.C. counties, Prince George's and Montgomery, and to most of the counties of the Baltimore Metropolitan area, that is, Baltimore City, Baltimore County, Anne Arundel, Howard and Harford Counties. However, Carroll County, which is also part of the Baltimore Metropolitan area for census purposes is classified as part of "Western Maryland" and is treated as a rural area.

In fact, Carroll County has a projected population of 179,700 in 2010, and is growing rapidly. Its population is comparable to that of Harford County which is subject to the urban threshold. Furthermore not only is Carroll now far more comparable in its primary characteristics to urban counties such as Howard, Harford and Baltimore County than to the counties with which it is now grouped, Garrett, Allegany, Washington and Frederick, but it is likely by 2010 to be even more like the Baltimore suburban counties.

The rationale for the policy of separate thresholds is stated on page 49 of the proposed plan:

> "In some rural areas, there may be a single hospice provider. Steps should be taken for the provision of hospice services if a sole provider ceases operation. In addition, it is more difficult for a small number of rural providers to absorb additional clients than for providers in urban areas that have multiple hospice programs. For these reasons, different volume thresholds should be developed for urban and rural areas."

The policy itself reads:

> Policy 9.1. The Commission will calculate a separate volume threshold, based on average length of stay and average daily census, for urban and rural jurisdictions in order to address access issues in jurisdictions with limited capacity.

Chart 3.2 (October 5 Revision) shows that Carroll County is similar to the Baltimore Area hospices and dissimilar to Western Maryland in terms of hospice capacity:

County	Number of Hospices
Baltimore County	10
Baltimore City	9
Howard	9
Anne Arundel	9
Carroll	8
Harford	8
Garrett	1
Allegany	1
Washington	2
Frederick	5

Furthermore, the listing of providers in the chart indicates that the set of providers in Carroll County substantially overlaps the set of providers in the rest of the Baltimore region. As an example, seven of the eight providers in Carroll County provide services in Baltimore City and Baltimore County.

Charts 3.2 and 3.3 indicate that more patients were admitted to hospice service in Carroll County than in Harford or Howard in 2004, and the total served in 2004 was approximately the same in Carroll and Howard and exceeded Harford. Carroll's admissions and total patients served far exceeded the totals for any other County in the Western Maryland region.

Seasons believe that Carroll County does not qualify in any way as a "rural" county for the purposes of Policy 9.1. Accordingly, the urban threshold should be applied, in which case there will be no net need in 2010 for a new program in that county.

2. **General Comments on Need.**

As the Commission itself is well aware there is a severe shortage of trained personnel in Maryland. Indeed, the proposed plan section itself notes in the subsection relating to home health services:

> "Given the statewide, as well as nationwide, shortage of home care nurses and aides, many home health agencies may be unable to maintain a sufficient number of staff to serve a larger number of home health clients. The home health industry may be at a disadvantage when competing with hospitals and nursing homes for a limited pool of nursing resources. Many home health agencies cannot offer the relatively higher salaries and benefit packages offered by hospitals and nursing homes.
>
> Moreover, with a finite number of available healthcare professionals, staffing shortages can be expected to become more serious as the population ages, patients' care needs become more medically complex and the demand for a greater number of healthcare professionals increase. Since the home health industry relies greatly on skilled nurses and nurse's aides, as well as physical therapists, there is concern about future supply of these workers on continued access to needed home health agency services." *Id.* at 32-33."

Obviously, the Plan's discussion of skilled labor shortages as to home health is relevant to hospice care as well. Indeed, Seasons experience reinforces the discussion in the Plan. As an example, the average annual salary for nursing staff employed by Seasons in the Chicago area is $56,046.42. The comparable salary in the Baltimore region for Seasons is $59,898.28, a difference of $3,852 per employee between Baltimore and Chicago. Furthermore, the Medicare reimbursement for the Baltimore region is substantially lower than that for the Chicago area.

In such an environment, it would be far preferable for existing providers in well-served areas to expand to serve any additional need. With a larger number of patients, existing providers would have greater resources available to care for patients, to improve quality and to innovate. New providers, by contrast, will require the hiring of new administrative staff and will bid up the already high cost of nursing staff.

Whatever the merits of increasing competition and patient choice in an area with only one or two hospice programs, in highly competitive markets such as the Baltimore or Washington areas the addition of new hospice programs will only increase the administrative cost and burden, will increase the competition for scarce staff and will increase the competition for a finite number of volunteers. Yet, there would be few if any advantages in terms of patient care.

Indeed, the escalating costs for staff and administration in light of lower reimbursement rates will reduce the resources available for patient care and could lower the quality of care. On the other hand, the economies of scale in allowing existing providers to develop higher volumes of patients serves to mitigate the cost and revenue pressures faced by Maryland providers, and may ultimately result in lower costs per patient for all payors.

We believe that the MHCC should consider carefully its need assumptions with respect to approving additional programs. In jurisdictions in which there already exist a large number of providers and substantial patient choice in providers, the existing providers should be allowed to expand to fill the projected need. This would permit the need to be satisfied in the most efficient and cost effective manner while not compromising the competitiveness of the system nor restricting patient choice.

3. <u>One Hospice Counties.</u>

In a number of counties, only one hospice is available to serve patients. Unlike the situation described above, in a one hospice jurisdiction, there is little competition, restricted patient choice, and the ongoing possibility that the one hospice might close or restrict operations, or suffer licensing problems at a bad time for a family. Seasons believes that in one hospice jurisdictions, existing hospices in adjoining counties should have the ability to provide appropriate hospice services upon request by a family dissatisfied by the existing option in the county. This change in the Plan would result in greater choice for patients while at the same time not significantly altering the distribution of resources in the State.

We would like to thank you once again for the opportunity to submit these comments.

Sincerely,

Stephen J. Sfekas

/sjs